

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2012
FORM APPROVED
OMB NO. 0938-0391

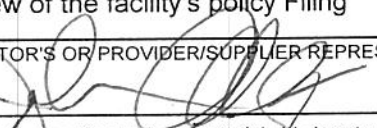
45th 5/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2012
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NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664
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F 000	INITIAL COMMENTS	F 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.	
F 166 SS=D	<p>Complaint #29360 was investigated during the annual Recertification survey conducted March 26-28, 2012 at Holston Manor. The complaint was substantiated with Deficiencies cited.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to resolve a grievance for one (#177) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #177 was admitted to the facility on December 4, 2009, with diagnoses including Rheumatoid Arthritis, Chronic Pain, Muscle Weakness, and Anemia.</p> <p>Medical record review of the Minimum Data Set (MDS) dated January 6, 2012, revealed the resident was independent with daily decision making.</p> <p>Observation on March 27, 2012, at 2:55 p.m., revealed the resident seated in a wheelchair, in the resident's room, conversing with a visitor.</p> <p>Review of the facility's policy Filing</p>	F 166	<p><u>F 166</u></p> <p>5/4/12</p> <ol style="list-style-type: none"> Missing cosmetic bag was replaced on 4/12/12. Any residents who have any grievances/complaints have the potential to be affected by the same deficient practice. Staff will be inserviced on the grievance/complaint process by the Social Services Department and/or designee by April 30, 2012. A random audit of residents will be completed by the Administrator and/or designee to ensure compliance with grievance/ complaint process. (4 residents per week x 4 weeks.) Quality Assurance Committee will review results during regularly scheduled 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	4/13/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	<p>Continued From page 1</p> <p>Grievances/Complaints revealed "...Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment...theft of property, etc., without fear of threat or reprisal in any form...upon receipt of a grievance and/or complaint, Social Services Dept will investigate the allegations and submit a written report of such findings to the Administrator within (5) working days of receiving the grievance and/or complaint...The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems..."</p> <p>Interview on March 28, 2012, at 8:30 a.m., with the resident, in the resident's room, revealed approximately two weeks ago the resident had reported a blue initialed cosmetic bag was missing to Licensed Practical Nurse (LPN) #1. Continued interview revealed the cosmetic bag was still missing.</p> <p>Interview on March 28, 2012, at 9:30 a.m., with LPN #1, in the hallway, confirmed the resident had reported the missing cosmetic bag. Continued interview confirmed LPN #1 had not reported the missing cosmetic bag to social services.</p> <p>Interview on March 28, 2012, at 10:15 a.m., with the Director of Nursing, in the hallway revealed Social Services was to be notified of missing items to enable the facility to search for the missing item.</p> <p>Interview on March 28, 2012, at 10:30 a.m., with</p>	F 166	<p>meetings to evaluate findings and amend plan as necessary.</p> <p>Completion Date: 5/4/12</p>		

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F 166	Continued From page 2 Social Worker #1, in the Social Services office, revealed missing items are placed on a grievance log, so the item could be searched for and a like replacement made if the missing item was not found. Continued interview confirmed the missing cosmetic bag had not been reported to Social Services.	F 166		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F278 1. A correction to the previous assessment was completed on 3/27/12 on resident #35. The correction stated that the resident did have a condition or chronic disease that might result in a life expectancy of less than six months. 2. All residents are at risk for inaccurate coding. 3. The Interdisciplinary Team will be inserviced on ensuring the accuracy of the Minimum Data Set by the Director of Nursing and/or designee by 4/30/12. 4. Random audits will be completed by the Care Plan Director and or DON to ensure accuracy of the MDSs. (4 residents weekly x 2 weeks, then 2 residents weekly x 2 weeks.) . Quality Assurance Committee will review results during regularly scheduled meetings to	5/4/12

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F 278	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for one (#35) of forty-two residents reviewed. The findings included: Res #35 was admitted to the facility on January 26, 2012, with diagnoses including Alzheimer's Disease, Dementia, Psychosis, Chronic Airway Obstruction, Hypertension, Obesity, and Esophageal Reflux. Medical record review of the Hospice Certificate of Terminal Illness dated October 20, 2011, revealed "...Narrative composed by Hospice physician:...if illness runs usual course life expectancy is 6 months or less..." Medical record review of the MDS dated February 2, 2012, revealed the MDS did not reflect the resident had a condition or chronic disease that might result in a life expectancy of less than six months. Interview on March 27, 2012, at 4:25 p.m., with MDS Coordinator #1, in the conference room, confirmed the MDS dated February 2, 2012, did not reflect the resident had a condition or chronic disease that might result in a life expectancy of less than six months and was not accurate.	F 278	evaluate findings and amend plan as necessary. Completion date: 5/4/2012		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 4</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to revise the care plan for one resident (#233) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #233 was admitted to the facility on October 4, 2011, with diagnoses including Atrial Fibrillation, Chronic Airway Obstruction, and Depression.</p> <p>Medical record review of the current Interdisciplinary Care Plan reviewed December 29, 2011, revealed "...self care deficit...resident will be clean, odor free, and provide</p>	F 280	<p><u>F280</u></p> <ol style="list-style-type: none"> 1. A significant change assessment will be completed by April 16, 2012 for resident #233. 2. All residents have the potential to be affected by the same deficient practice 3. Interdisciplinary Team Members will be inserviced by the Director of Nursing and/or Risk Manager regarding keeping the Care Plans up to date and current with new orders and resident status changes. Inservice to be completed by 04/30/2012. 4. Random audits of resident's care plans will be performed to ensure compliance. (4 careplans per week x 4 weeks by the Care Plan Director and or designee) Quality Assurance Committee will review results during regularly scheduled meetings to 		5/4/12

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F 280	Continued From page 5 assistance...with transfers...mobility...decreased mobility...reposition with extreme care...for comfort..." Medical record review of a nurse's note dated January 11, 2012, revealed "...the resident required assist of one for ADL's (activities of daily living) and mobility..." Medical record review of the CNA (certified nurse aide) ADL Flow Record dated March 2012, revealed the resident requires supervision for transfers, bed mobility, toilet use..." Observation on March 26, 2012, at 10:30 a.m., in the resident's room revealed the resident exited the bed, independently transferred to the wheel chair, and entered the bathroom. Interview with MDS (Minimum Data Set) Coordinator #2 (responsible for the care plan), in the MDS office, on March 26, 2012, at 5:26 p.m., confirmed the Care Plan had not been updated to reflect the residents current condition.	F 280	evaluate findings and amend plan as necessary. Completion Date: 5/4/12		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide a restorative program for one resident (#247) of forty-two residents reviewed.	F 311			

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F 311	<p>Continued From page 6</p> <p>The findings included:</p> <p>Resident #247 was admitted to the facility on January 13, 2012, with diagnoses of Malignant Brain Tumor, Aphasia, Depression, Anxiety, and Feeding Tube.</p> <p>Medical record review of the Minimum Data Set dated January 20, 2012, revealed the resident was severely impaired cognitively and required total dependence for all Activities of Daily Living (ADL).</p> <p>Medical record review of a Rehabilitation Screening dated January 13, 2012, revealed "...OT not appropriate at this time...PT oof (out of facility)...1/16/12...SLP (Speech Therapy)...pt (patient) unavailable..."</p> <p>Medical record review of Rehab Services Recommendations for Restorative Nursing Program dated January 22, 2012, revealed "...start date January 23, 2012..."</p> <p>Medical record review of a Physician Telephone Order dated January 22, 2012, revealed "...RST (restorative) NSG (nursing) 5 x (times) a wk (week) x 8 wk for positioning, ADL's, and Range of Motion (ROM).</p> <p>MD (medical doctor) progress note dated February 10, 2012, revealed "...Physical Therapy was delayed upon admission..."</p> <p>Medical record review of the resident's chart revealed no rehabilitation notes until March 9, 2012, forty-six days later.</p>	F 311	<p><u>F 311</u></p> <ol style="list-style-type: none"> 1. Resident #247 – Restorative order d/c'd. PT started treating resident on 2/7/12, and 2/9/12. 2. All residents who have orders for restorative nursing have the potential to be affected by the dame deficient. 3. Inservice will be provided to Rehab, Restorative, Restorative Supervisor on communication r/t new restorative orders by the Director of Nursing and/or ADON by April 30, 2012 4. Random audits of residents charts will be performed by the Director of Nursing and/or ADON. (4 residents per week x 4 weeks) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. <p>Completion Date: 5/4/12</p>	5/4/12	

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F 311	Continued From page 7 Observation in the resident's room, on March 26, 2012, at 4:00 p.m., revealed the resident lying on the bed. Observation on March 27, 2012, at 1:15 p.m., in the resident's room, revealed the resident being fed per the nursing home staff. Interview with the Rehabilitation Interim Manager on March 27, 2012, at 3:43 p.m., in the rehabilitation gym, confirmed the facility failed to provide a restorative program for the resident. Interview with the Director of Nursing on March 27, 2012, at 3:30 p.m., in the Director of Nursing office confirmed the facility had an order for restorative nursing and failed to provide the program for the resident.	F 311			
F 323 SS=D	C/O #29360 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one (#193) of forty-two	F 323			

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F 323	<p>Continued From page 8 residents reviewed.</p> <p>The findings included:</p> <p>Resident #193 was admitted to the facility on January 5, 2012, with diagnoses including Congestive Heart Failure, Muscle Weakness, Dementia, Urinary Tract Infection, Diabetes, Hypothyroidism, and Generalized Pain.</p> <p>Medical record review of the Risk for Falls assessment dated January 5, 2012, revealed the resident was at risk for falls.</p> <p>Medical record review of the Minimum Data Set dated January 12, 2012, revealed the resident required extensive assist of one person for transfers and walking.</p> <p>Medical record review of the March 2012, physician's recapitulation orders revealed "...hipsters on at all times except showering/bathing..."</p> <p>Medical record review of the Care Plan reviewed on January 20, 2012, revealed "...Potential for falls...hipsters at all times but bathing, for safety unsteady on feet..."</p> <p>Observation on March 27, 2012, at 1:15 p.m., revealed the resident seated in a wheelchair with a safety alarm in place.</p> <p>Observation and interview, on March 27, 2012, at 1:50 p.m., with the Director of Nursing, in the resident's room, revealed the resident seated in a wheelchair and confirmed the hipsters were not in place.</p>	F 323	<p><u>F 323</u></p> <ol style="list-style-type: none"> Hipsters were immediately placed on resident #193. All residents who have an intervention for Hipsters are at risk to be affected by the same deficient practice. All residents with this intervention were checked on 3/27/2012 to ensure compliance. A list of interventions will be placed at each Nurse's Station. Staff to be inserviced by 4/30/2012 regarding compliance with interventions related to resident safety by the Risk Manager and/or designee. Inservicing to be completed by 4/30/2012. Random audits will be performed to ensure compliance. (10 residents weekly x 4 week) by the Risk Manager and/or designee. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. 		5/4/12

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F 406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide physical therapy services in a timely manner for one resident (#247) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #247 was admitted to the facility on January 13, 2012, with diagnoses of Malignant Brain Tumor, Aphasia, Depression, Anxiety, and Feeding Tube.</p> <p>Medical record review of the Minimum Data Set dated January 20, 2012, revealed the resident was severely impaired cognitively and required was totally dependent for all Activities of Daily Living (ADL).</p> <p>Medical record review of the physician admission orders dated January 13, 2012, revealed "...Rehab Services: Physical Therapy... Occupational Therapy...eval (evaluation) and</p>	F 406	<p><u>F 406</u></p> <ol style="list-style-type: none"> 1. Resident #247 started receiving Physical Therapy on 2/7/12 and Occupational Therapy on 2/9/12. 2. All residents admitted with therapy orders have the potential to be affected by the same deficient practice. 3. Rehab department will be inserviced by 4/30/12 to ensure that all new admission's orders are to be reviewed by Therapy within 24 hours except on Friday, and Saturday. Those will be reviewed on Monday. This is to ensure compliance with Therapy orders on new admissions to our facility. 4. Random Audits of 4 new admissions x 2 weeks. Then 2 	5/4/12	

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F 406	<p>Continued From page 10 treat..."</p> <p>Medical record review of the January 2012 Physician Recapitulation Orders revealed "...P.T. (Physical Therapy) to screen and treat as indicated...O.T. (Occupational Therapy)...to screen and treat as indicated..."</p> <p>Medical record review of the Rehabilitation Screening dated January 13, 2012, revealed "...OT not appropriate at this time...PT oof (out of facility)...1/16/12...SLP (Speech Therapy) ...pt (patient) unavailable..."</p> <p>Medical record review of a MD (medical doctor) progress note dated February 10, 2012, revealed "...Physical Therapy was delayed upon admission..."</p> <p>Observation in the resident's room, on March 26, 2012, at 4:00 p.m., revealed the resident lying on the bed.</p> <p>Observation on March 27, 2012, at 1:15 p.m., in the resident's room, revealed the resident being fed per the nursing home staff.</p> <p>Interview with the Registered Physical Therapist, on March 27, 2012, at 3:50 p.m., in the front lobby, confirmed the resident was not screened on admission for Physical Therapy until February 1, 2012, resulting in an eighteen day delay in providing services.</p> <p>Interview with the Rehabilitation Interim Manager on March 27, 2012, at 3:43 p.m., in the rehabilitation gym, confirmed the facility failed to screen and provide Physical Therapy on</p>	F 406	<p>new admissions x 2 weeks will be completed by the Rehab Manager and/or DON to ensure compliance with Therapy orders. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion Date: 5/4/12</p>		

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F 406	Continued From page 11 admission.	F 406			
F 425 SS=D	<p>C/O #29630</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to provide pharmacy services timely for one (#112) resident of forty-two residents reviewed.</p> <p>The findings included:</p>	F 425	<p><u>F425</u></p> <ol style="list-style-type: none"> 1. Resident expired on 1/13/2012. 2. All residents who receive new pain medication orders are at risk for being affected by the same deficient practice. 3. Licensed Nurses will be inserviced on medication administration directly related to receiving pain medication in a timely manner by the Director of Nursing and/or ADON by 4/30/12. 4. Random Audits will be performed on residents with new pain medication orders by the Nursing Supervisor and/or ADON. (4 residents per week x 2 weeks, then 2 residents per week x 2 weeks. Quality Assurance Committee will 		5/4/12

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F 425	Continued From page 12 Resident #112 was admitted to the facility on December 23, 2011, with diagnoses including Malignant Neoplasm Prostate, Hypertension, Osteoarthritis, and Senile Dementia. The resident expired at the facility on January 13, 2012. Medical record review of a physician's order dated January 6, 2012, at 6:15 p.m., revealed "...MS (Morphine Sulfate) Contin (pain medication) 15mg (milligrams) po (by mouth) Q (every) 12 (hours) scheduled. Discontinue Tramadol. Continue Roxanol (pain medication) 20mg/ml (milliliter) 0.25 ml po/sl (sublingual) Q 4 (hours) prn (as needed) breakthrough pain. Begin MS Contin as soon as available from pharmacy (with) 1st dose now..." Review of the Medication Administration Record dated January 2012, revealed the first dose of MS Contin 15mg was not initialed as administered until January 7, 2012, at 8:00 p.m. Interview on March 28, 2012, at 1:20 p.m, with the Director of Nursing, in the conference room, confirmed a delay in providing pharmacy services.	F 425	review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion Date: 5/4/12		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441			

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F 441	<p>Continued From page 13</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation facility policy review and interview, the facility failed to follow the facility's policy for infection control for hand washing during tray pass on the 300-hundred hall for three observed residents.</p>	F 441	<p><u>F 441</u></p> <ol style="list-style-type: none"> 1. CNA #1 and #2 received verbal counseling regarding failure to follow handwashing policy. 2. All residents have the potential to be affected by the same deficient practice. 3. Staff will be inserviced on handwashing by the Risk Manager and/or designee by 4/30/12. 4. Random handwashing observations will be performed at meal times to ensure compliance by the Risk Manager and/or designee (2 meals audits per week x 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. 		5/4/12

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F 441	Continued From page 14 The findings included: Observation on March 26, 2012, at 12:39 p.m., on the 300-hundred hall revealed Certified Nurse Aide (CNA) #1 and CNA #2 serving the lunch trays. Further observation at this time revealed CNA #2 entered a resident's room served a lunch tray, exited the room requested CNA #1 to assist in positioning the resident, and then CNA #1 and CNA #2 exited the resident room and continued to pass lunch trays without washing hands or using sanitizer. Review of the facility policy Handwashing/Hand Hygiene revised December 2009, revealed "...employees must wash their hands...before and after direct resident contact...if hands are not visibly soiled use an alcohol-based hand rub..." Interview with CNA #1 on March 28, 2012, at 9:00 a.m., in the 600 Nurse's Station, confirmed hand washing or hand sanitizing had not been performed between contacts with the residents. Interview with the Director of Nursing on March 28, 2012, in the conference room, confirmed all employees are to wash or sanitize hands between contacts with the residents.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514			

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F 514	<p>Continued From page 15</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure the medical record was accurate for one (#221) resident of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #221 was admitted to the facility on December 16, 2011, with diagnoses including Pneumonia, Psychosis, Venous Thrombosis, and Chronic Kidney Disease.</p> <p>The resident expired at the facility on January 5, 2012.</p> <p>Medical record review of a physician's order dated January 5, 2012, revealed, "...Ativan 0.5mg (milligrams) IM (intramuscular) q (every) 6 (hours) prn (as needed) (anxiety)..."</p> <p>Medical record review of the nurse's note dated January 5, 2012, revealed, "...Ativan 0.5mg IM given for anxiety...(signed by RN (Registered Nurse) Supervisor #1)"</p> <p>Review of the Medication Administration Record dated January 2012, revealed no documentation the Ativan was administered on January 5, 2012.</p>	F 514	<p><u>F514</u></p> <ol style="list-style-type: none"> 1. Resident #221 expired on 1/5/12. 2. All residents have the potential to be affected by the same deficient practice 3. Medication Administration specifically related to signing medications being given, inservices will be provided by the Director of Nursing and/or designee by April 2012 4. Medication pass evaluations will be completed by Nursing Supervisor and or Risk Manager to ensure compliance with documentation (3 medication passes will be performed weekly x 4 weeks. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. <p>Completion Date: 5/4/12</p>		5/4/12

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F 514	Continued From page 16 Review of the policy, Administering Medications revealed, "...The individual administering the medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication...the individual administering the medication will record in the resident's medical record...The date and time the medication was administered...The signature and title of the person administering the drug..." Interview on March 28, 2012, at 8:05 a.m. in the conference room, with RN Supervisor #1 confirmed the Ativan administered on January 5, 2012, was not documented on the Medication Administration Record. Further interview confirmed RN Supervisor #1 documented the Ativan was given in the nurse's note on January 5, 2012, but a different nurse administered the Ativan. Interview on March 28, 2012, at 10:15 a.m. in the hall with the Director of Nursing confirmed the Ativan was to be documented by the nurse administering the medication.	F 514			

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